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ORIGINAL PAPER

Emotion Focused Therapy for Avoidant Personality Disorder: Pragmatic Considerations for Working with Experientially Avoidant Clients

Alberta E. Pos

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Abstract Emotion-focused therapy (EFT), an empirically supported treatment for depression and interpersonal difficulties, is now being directed towards clients with personality disorders, such as borderline and avoidant personality disorder. In this paper, both the value of, but also potential difficulties therapists can encounter while engaging in, active EFT chair interventions with clients with avoidant personality disorder (AVPD) are described. While EFT interventions can effectively transform emotion schemes at the heart of both intra and interpersonal difficulties, avoidant clients may have difficulties engaging in EFT interventions that activate core maladaptive emotion schemes related to self and negative/unaccepting representations of 'others'. Alliance ruptures, intransigent experiential avoidance, or 'unresolvable stand-offs' may result. To avoid these problems, the importance of working with a more refined and content based case conceptualization of the particular avoidant client is highlighted. Guidance in optimal emotional processing in order to transform layers of maladaptive emotion schemes present within the client with AVPD is provided. Supporting these clients' full striving for life, and their capacity to self-soothe is also discussed. A case example illustrates application of the model and principles.

Keywords Emotion-focused therapy · Avoidant personality disorder · Anxiety · Personality disorder

A. E. Pos (✉)
Department of Psychology, York University, 4700 Keele Street, Toronto, ON, Canada
e-mail: aepos@yorku.ca

In recent years Emotion-focused therapy (EFT) has been recognized as an effective treatment for depression (Greenberg and Watson 2006), couples distress (Greenberg and Goldman 2008) and complex trauma (Paivio and Pascual-Leone 2010). Now EFT is being explored as a treatment for borderline personality disorder (BPD; Pos and Greenberg 2012) and social phobia/anxiety (Elliott 2013). The utility of applying experiential approaches to anxiety disorders has been highlighted for some time (Borkovec 2002; Elliott 2013; Wolfe and Sigle 1998); and Elliott (2013) reports early evidence that EFT for social phobia (SP), rivals the effectiveness of CBT for SP, with effects appearing robust at follow-up. Symptoms of avoidant personality disorder (AVPD), an anxious Cluster C personality disorder of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision, American Psychiatric Association (2000) and generalized social phobia (GSP; Alden et al. 2002; Chambless et al. 2008) highly overlap. AVPD, however, is still considered a distinct disorder associated with greater depression, introversion, disability, dysfunction and interpersonal problems, more frequent comorbid eating disorders, as well as lower social support and lower experience of positive emotions (Carr and Francis 2010; Hummelen et al. 2007; Marques et al. 2012; van Velzen et al. 2000). Clients with AVPD more pervasively devalue and despise parts of the self, as well as exhibit more 'primitive' attempts to reduce anxiety and preserve self-esteem (Hummelen et al. 2007). Some evidence also indicates that environmental factors differ in the development of AVPD versus GSP (Eggum et al. 2009; Reichborn-Kjennerud et al. 2007; Rettew et al. 2003). EFT for AVPD, presently under development is the focus of this paper.

EFT for AVPD has emerged out of a task analytic methodological investigative strategy (Greenberg 2007)

involving clinically observing and documenting successful and unsuccessful clinical attempts to apply EFT to approximately one dozen clients meeting criteria for AVPD. During the development of this approach, EFT for AVPD has become a more integrative treatment that accommodates systems therapy principles (EFT for couples; Bowenian family therapy) concerning regulation and differentiation of emotion relating to triggering maladaptive interpersonal cycles, cognitive behavioral principals relating to the importance of explicit teaching or psychoeducation, and psychodynamic theory which provides understanding as to why clients with AVPD may struggle with active EFT interventions.

The clinical challenge in treating AVPD in general will first be discussed. Converging rational for integrative treatment follows. The case for EFT as an optimal integrative treatment for AVPD will then be made. Following this, a newly developed EFT model for step-wise work with AVPD will be presented, exemplified by a case illustration. The article closes with summary EFT strategies for working with AVPD.

The Client with Avoidant Personality Disorder (AVPD)

Clients who meet DMS-IV-TR (APA 2000) criteria for a diagnosis of AVPD are extremely sensitive to negative evaluation. Viewing themselves socially inept or personally unappealing, they avoid social interaction (occupational, intimate and even general), expecting it to lead to personal ridicule, humiliation, rejection, or dislike from others. These fears cause the client with AVPD to avoid new social situations as well, unless guaranteed of acceptance or success. Isolated from others, clients with AVPD still deeply want human contact (Benjamin 2003) often describing themselves as lonely.

The high prevalence of AVPD (Torgersen et al. 2001) and the relatively few studies on treatment for AVPD (Beretta et al. 2005; Emmelkamp et al. 2006; Muran et al. 2005; Strauss et al. 2006) argue for continued work on developing treatment for AVPD (Alden et al. 2002; Ahmed et al. 2012).

General and Particular Struggles of the Client with AVPD

Dimaggio et al. (2012a, b) summarize difficulties for clients with PDs expressing trait inhibition, noting three core domains of difficulty: maladaptive interpersonal patterns, emotional processing difficulties, and poor metacognitive functioning.

Maladaptive interpersonal patterns are the 'sine qua non' of any PD diagnosis. The cognitive affective structures responsible for this dysfunction are called internal working models in dynamic approaches (Bowlby 1979); early maladaptive schemas in cognitive approaches (Carr and Francis 2010); or *maladaptive interpersonal cycles* in EFT for couples (Greenberg and Goldman 2008). These related concepts all point to internally operating cognitive-affective structures formed during early attachment histories. Operation of these structures problematically organizes our perception of self and others, causing dysfunctional interpersonal thought, feeling and behavior in our current adult relationships.

Maladaptive interpersonal cycles are core targets of PD treatment (Benjamin 2003; Pos and Greenberg 2012). Clients with PDs are well known to suffer troubled attachments, and are highly vulnerable to becoming enmeshed in attachment issues related to important others. As a result, a triggering interpersonal event often causes clients with PDs to emotionally respond not as individuals. Instead, their emotional response becomes 'driven' by activated higher level maladaptive emotional cycles *between* self and others (or parts of self). This is akin to their finding themselves dancing with a partner before agreeing to dance. The client feels unwittingly caught up in a system of emotional action and reaction, 'danced by' the interpersonal event.

As for the maladaptive interpersonal cycles operating in AVPD, dynamic writers believe the client with AVPD experiences good initial attachment experiences that maintain both longing for connection to, strong loyalty to, and idealization of close others (Benjamin 2003; Muller 2010). However, later harsh criticism and rejection cause the client with AVPD to internalize a view of self as inadequate and others as sources of rejection, criticism and humiliation. Of sensitive temperament (Eggum et al. 2009; Rettew et al. 2003) the client 'regulates' interpersonal pain by withdrawing from and avoiding closeness (Eggum et al. 2009), choosing to subjugate to others and/or inhibit their feelings (Carr and Francis 2010).

This points us to particular emotional processing 'style' for the client with AVPD- automatic emotional/experiential avoidance. They do not mentalize their emotional life well (Nicolò et al. 2011), are over-controlled, and avoid salient emotional triggers (Benjamin 2003). Findings suggest that lower emotional awareness at treatment onset does predict poorer outcomes for AVPD clients (Borge et al. 2009). The AVPD client is thought to inhibit feelings in a number of ways, through 'deactivating attachment feelings' (Muller 2010), occasional angry outbursts (Benjamin 2003; Eggum et al. 2009) and situation avoidance (APA 2000). Also, being highly rational, these clients avoid feeling by focusing their attentional resources on

thought processes (Borkovec 2002; Muller 2010). Non-specific autobiographical memory is also common (Spinhoven et al. 2009) which attenuates experienced arousal related to affect-laden memories.

Poor metacognition/mentalization (Fonagy et al. 2002) naturally follows emotional processing difficulties emerging from activation of maladaptive interpersonal cycles. The client with AVPD oscillates between fearing and fleeing triggers that activate their 'demand-for- closeness' fear. 'Flee-ing' internal experience by a narrowing attentional focus, going into their heads and/or shutting down, they are unwitting and 'overworked experts' at avoiding feeling. As a consequence they are in exile from reflecting on or experiencing their deepest values, wishes and needs (Damasio 1999).

Core treatment questions to ask and answer when working with a client with AVPD are: How do I create a strong alliance with a client who avoids connection and novel tasks? How do I help a client access, tolerate, and reflect on their emotional experience when the client automatically avoids feelings? And finally, how can I restructure vaguely articulated and under- experienced maladaptive interpersonal cycles inaccessibly hidden in the client's 'shadow'?

Treatment of AVPD

While attempts to articulate treatment of AVPD have been made (Benjamin 2003; Dimaggio et al. 2012a, b; Kernerg et al. 2008) no generally accepted specific treatment of AVPD presently exists. Still, agreement is emerging that integrative treatment for PD is most effective (Dimaggio et al. 2012b; Livesley 2003). Treatment principles to guide such treatments are also emerging. The APA task force (Critchfield and Benjamin 2006) suggests such integrative treatments should exhibit strong alliances built by specially trained therapists who are comfortable with long term emotionally intense relationships and who can provide patients empathy, acceptance, and congruence. Treatment interventions should match clients' functional impairment and readiness to change; and treatment should be adequately structured, balancing acceptance and change principles. Clients should also be provided salient and transparent connections between intervention and treatment goals, with the core goal being increasing clients' flexible and adaptive functioning.

Why EFT for AVPD?

EFT is an integrative treatment meeting many APA Task Force for PD treatment principles. It has empirically demonstrated that strong relationship and active emotional processing task intervention produce emotional change (Pos et al. 2009). Offering a fundamentally genuine, empathically attuned relationship EFT therapists attend to client 'markers' that communicate readiness to focus on particular emotional processing difficulties. These markers then guide the accepting EFT therapist towards engaging the client in structured interventions designed to best resolve their particular emotional processing difficulty (see Elliott et al. 2004; Greenberg and Watson 2006).

This paper describes an optimal sequence of EFT intervention taken by AVPD responders versus non responders to EFT for AVPD. In addition, treatment guidelines to scaffold clients' capacity to tolerate and reflect on emotion and reduce alliance ruptures are offered.

Core principles of EFT will first be discussed. The problem of the 'un-individuated' client in active EFT intervention follows. A case example then provides a grounded description of the stage wise series of chair-work intervention which occurs for 'responders' to EFT for AVPD.

EFT in a Nutshell

EFT views *emotion schemes* as the core driver of behavior self,-organization, and meaning making. These are dynamic integrations of multiple levels of functioning (perception, sensation, cognition, memory, affect, physiological changes). Activating emotion schemes in session is thought essential to change as it facilitates clients attending to, experiencing, making sense of, and finally transforming them. Activating new adaptive emotion schemes in particular is thought to provide healthy motivation, new self/other experiences, and 'affective antidotes' to more problematic emotional schemes (Greenberg and Watson 2006). To do this EFT therapists constantly assess and regulate clients towards optimal levels of arousal (neither under nor over-aroused) during active interventions (Greenberg and Goldman 2011).

Four distinct classes of emotion schemes are identified in EFT, each worked with differently in EFT therapy. *Primary adaptive emotion schemes* are healthy immediate emotional responses to situations that help organize appropriate action in service of basic needs to support survival. Therapists help clients explore primary adaptive emotion schemes for implicit and motivating adaptive needs and accurate self/world appraisals. *Primary maladaptive emotion* schemes are also immediate responses. These over-learned responses from previous, often traumatic, experiences are explored and validated for the original historical context within which they were once adaptive. They are then transformed by therapists supporting clients' experience of needs and

appraisals that make adaptive sense in the present. *Secondary emotional schemes* are emotional reactions to primary emotional experiences, as when avoidant clients feel fear of experiencing core adaptive anger or maladaptive shame. They can also be secondary to internal thought processes, such as when clients feel self-contempt after thinking: "I'm a loser". Secondary emotion schemes are understood as having emotion regulation functions (self-interruption of deeper painful experience), and are explored within this context. Finally, *instrumental emotion schemes* occur to obtain an outcome. They are potentially habitual responses reinforced over time through obtaining desired consequences (comfort after crying).

These emotion scheme types are viewed as occurring within three broad emotional processing problem domains. First, individuals can be in exile from all emotional experience and be unable to access any adaptive meaning such experience can provide. Avoidant clients are often cut-off from experiencing their basic needs and feelings. This 'experiential avoidance' is a marker for *focusing* intervention to help clients attend internally. A second core problem is chronic activation of secondary emotion schemes when first- occurring emotions are difficult to tolerate (i.e. fear of shame). Such reactions inform a therapist about the client's tolerance for and perhaps beliefs about emotions. Secondary emotion schemes also cause clients to experience split senses of self. These take many forms: self-criticism, self-interruption, self-frightening. At markers of self-splits therapists engage clients in two-chair (self-split) interventions in which a hostile emotional relationship between two self-states is explored and resolved. A third emotional processing difficulty is the activation of primary maladaptive emotion schemes that cause 'false alarms', 'over-reactions' and the activation of maladaptive interpersonal cycles. Primary maladaptive emotion is a marker for empty-chair work or unfinished business (UFB). Unresolvable empty-chair work can, in turn, be a marker for unregulated internal distress suggesting self-soothing intervention (see Elliott et al. 2004). Clients with AVPD, exhibit all of these global emotional processing difficulties. They will therefore provide the EFT therapist with markers for engaging in many EFT tasks.

One additional EFT assumption is important. EFT views a healthy individual as naturally composed of multiple selves (Markus and Nurius 1986), as dialogical and multivoiced (Dimaggio and Stiles 2007). EFT views personality as the human tendency to dynamically express a familiar (to us and others) recurring cast of emotion-based self-organizations over time and situations. Our self-narrative expresses consistency through the recurring stories provided by this cast of independent selves with their own beliefs, feelings and memories.

EFT Chair Work with the AVPD Client

Clients with AVPD are exquisitely sensitive to interpersonal rejection and criticism and are emotionally organized to automatically and quickly avoid experiencing such rejection. Yet active EFT chair-work intervention intentionally activates clients' primary maladaptive emotion schemes by employing emotionally alive interpersonal confrontations between imaginary negative others (whether intra or interpersonal) and another core experiencing-self. The potential danger in these active interventions is to activate runaway cycles of maladaptive interpersonal process. This is because once an 'expressed negative other' is activated, an un-individuated self, associated with that negative other, often co-activates. We have found three problematic outcomes often ensue: First, in order to manage the deep distress the un-individuated experiencing-self submits to the rejecting critic/other in interpersonally complementary ways (Benjamin 2003) ("she's right I am weak"). This amounts to activating a higher order maladaptive interpersonal cycle. Second, the un-individuated experiencing self, overwhelmed with experience, avoids or 'shuts down'. Third an 'oppositional' defiant self emerges who simply communicates 'no'. Arriving at any of these 'stuck places' in early chair work with the client with AVPD can 'stump' the therapist.

Clients with AVPD also have a deep need to deny problems and to appear 'normal' (Muller 2010). Because the client with AVPD is highly sensitive to criticism, even of their critic or important other, chair work often activates a deep AVPD need 'to be fair'. The client's capacity to access adaptive anger and set boundaries with others is then likely to be interrupted. Anger and task ruptures with the therapist also emerge if they perceive the therapist as 'unfair'.

Three sources of 'scaffolding' for both client and therapist will help resolve these issues: (1) a-more-than-usual-EFT guiding AVPD case formulation; (2) systems intervention tactics; and (3) relational and experiential intervention that bring the AVPD client closer to experience. A case that will ground the discussion of these issues.

The Case of 'Dieter'

Dieter (D; pseudonym) is a middle-aged gay man of German Catholic decent working as a contract lawyer for a small law firm. He met criteria for both AVPD and depression. His core concern was a pattern of work procrastination which resulted in his quitting 'to avoid being fired' when not functioning well. "I can't stop self-sabotaging (his words)". Unhappily still living in his parents' house, he felt he didn't measure up to his successful brother (successful married business man with children) and cousin

(professional soccer player). He avoided acting on personal interests, fearing they would appear weird. He never had had a gay or other romantic relationship, denied feelings of loneliness nor any wish for romance. He did like being close to family. He had not 'come out' to them but guessed they knew. They did, but never spoke of it. D also avoided feelings in general, telling me in our first interview that his family thought feelings were 'primitive' and 'unseemly'. When family conflict arose people would just 'leave' and no conflicts were ever resolved. His resilience appeared as a considerable amount of 'social grace' learned from his 'very proper Catholic' mother of which he was proud, and a capacity to name his feelings if he was held to experience them. He was smart, articulate, well-educated and read, and motivated.

AVPD Case Formulation

Humanist/experiential therapists often oppose diagnostic classification of clients on principle (Elliott 2013) choosing instead to dynamically co-construct a case formulation with the client. However the need for 'content informed' case formulation is essential when working with clients with AVPD who tend to 'hide their stories' (Muller 2010). After working with AVPD over time, broad emotional and narrative themes common in clients with AVPD have emerged, ones coherent with those found in extant clinical literature on AVPD.

Dieter did express early therapy narratives of being protective of his family. He expressed admiring respect for his father, and loyal love for his mother and siblings. Only after his father died of a heart attack 1 year into treatment did he describe his father as actively critical and domineering. His father expressed open disdain for anyone who was not like him, and had set D up for failure, humiliating and ridiculing him by often 'defeating me as a boy'. He accused D of being 'over-controlled and of small appetite' like his mother. And, though D did all he could to be 'good', his father admired and supported his 'bad-boy' brother more than him. D's mother, distantly judgmental, asked little from D. Seeing D as having 'mental problems', his mother 'protects him' by allowing him to live in the family home. D wants independence but falls back on his mother's support. In therapy for 4.5 years, D still has sessions twice monthly.

Integrating the AVPD literature with task analytic observation informed our emerging EFT for AVPD model of progressive maladaptive default coping strategies used by clients with AVPD. Hierarchically related, these coping strategies help the client avoid pain from activated maladaptive emotion schemes. They are: (1) 'just do it'—'be normal'; (2) 'hide, don't show yourself, protect yourself from future humiliation or failure'; (3) be angry about and criticize failure- your own or others; (4) shut down and freeze. Four separate split interventions (described below) helped D work through this maladaptive coping hierarchy. EFT for AVPD begins with this self-split work. Eventual UFB intervention will be eventually important to address issues aroused from splits, but also activates more powerful maladaptive interpersonal cycles and self-interruption as well. Split-work prepares the client with AVPD to eventually work through their UFB. Suggested here is not a 'flight path' but a 'terrain map' that orients clinicians to AVPD split processes and their internal 'emotion schematic' structure.

The 'Just be Normal' Split

D's immediate treatment focus was work on procrastination marked by a self-split between a 'be normal' self, and a self that would not/could not engage as asked. In this 'classic' initial AVPD split, the 'critic' is often not willing to be critical, and instead takes a more benign strategy of coaching the self on how 'to be normal'. To resolve this split, the core task is to get task agreement from both selves to work on deeper avoidance. To achieve this one must promote acceptance in the coach that there is something deeper that needs to be explored. This is D in his initial coach split. Note: 'exp-self' means 'experiencing-self'.

Vignette Level 1: The Coach/Critic Split

C: now really it's not going to be that hard, you need to just get organized and start to create a schedule for getting your job done, everyday go online and get the forms you need, get up every day at 6 am, eat a good breakfast, get to the office by 8 am and start working. Don't go to any sites that aren't work related, and the minute you start to fantasize, turn your mind to your work.

When he returned to the exp-self chair, the response there was "I know that's what I should do but I can't", or a simple 'no, I don't want to'. Moving back to the critic chair the therapist tried to bypass the coach by encouraging D to express deeper criticism. She modelled implicit critical things he might say as the inner critic that might highlight its harsh critical nature ("you're disorganized, dreaming all the time, get with the program, you're screwing up"). This did not work. D 'didn't want to'. D also 'knew' that in the face of harsh criticism his exp-self would get more oppositional. So even if the critic/coach were able to express harsh secondary anger (covering helpless shame) the exp-self remained 'unmoved'. The split therefore hit a dead end. The lesson here was that, 'mean' or 'nice', the coach/

critic was impotent and had no real power. The power was in the oppositional avoidant self. Since a default EFT strategy is for the therapist to use their 'internal pain compass' (Greenberg and Goldman 2011) to focus on current pain, exploring the coach critic's pain, the pain of being impotent in the face of the avoidant self's refusal to engage was suggested.

This was an important shift from EFT-'as usual'. In critical splits one normally does not work with the experience of the critic until it has softened from hearing the expressed pain of the exp-self and its assertive needs. However, in split work with AVPD clients, one must access the deeper painful experience in *whatever side of the split that is powerless in any given moment*. This core pain of helpless powerlessness and the need for support must be expressed in whatever chair it is currently activated. The dilemma was that in the coach-split both sides of the split were powerless, helpless, 'afraid' and 'angry'.

Systemic Interactional Strategies

EFT for couples (EFT-C; Greenberg and Goldman 2008) provides a strategy for resolving this impasse by supporting deep co-exploration of experience in both chairs during individual chair work (also see Pos and Greenberg 2012). The EFT-C therapist helps couples contact and communicate deeper primary affect and needs that can support attachment bonds by having an empathic, prizing and genuine relationship with *both* members of a couple. They short-circuit and de-escalate hostility from secondary anger and continuously reflect deeper primary feelings and needs. Doing this with self-organizations in dialogue during split-work not only creates a cognitive distance that regulates affect and enhances the capacity to reflect on interpersonal patterns, it also addresses the AVPD client's 'fair' nature and their need for split work that is 'warm' and 'egalitarian'. Another helpful systemic strategy is for the therapist to 'not allow' direct contact between parts. This increases differentiation between parts and regulates interpersonal triggering (Bowen 1985). Below the therapist connects individually with both critic and avoidant self, and activates the coach/critic's attached willingness to help.

Vignette Level 1: The Coach Split Continues

T: (to the frustrated coach critic) so what's it like for you to try so hard to be helpful, to tell him over and over again that he's in trouble, and he just doesn't respond, engage, or even care?
C: it's awful
T: it must leave you feeling so powerless (*reflects core pain*)
C: yea, and frustrated, I want to shake him, because he could be so great and he's doing nothing, it's like watching a train wreck in slow motion and our life is going down the toilet and he's doing nothing, he's wasting everything, letting it all slip away (*stays in secondary anger*)
T: go there to the train wreck… he won't engage, refuses, 'I can't' is what he says, tell him what he's making you let go of, and say goodbye to (*encourage experience of deeper pain again)*
C: it's so sad, we're going to be living at home forever, we're never going to be successful, we're never going to be able to feel proud of ourselves, no one will ever know how smart we are and what we can do (*some primary grief of the coach accessed and expressed to exp-self*)
T: it's so painful to see that crumbling (*holding the client in the pain*)
C: I don't understand, I don't know what to do (*experiential avoidance into cognition/action)*
T: yeah you feel helpless, so what do you need from him? (*redirect to core pain and need)*
C: I need him to just stop avoiding (*secondary anger)*
T: yes that would be great, but he can't yet, don't you also want to understand what's in his way? (*went with 'need to know', often a deep need in clients with AVPD*)
C: yes, that's true, I do want to understand all this
T: and to know how to help him?
C: yeah that's true too, I need him to help me help him, I'll do anything to help him (*access the AVPD attached willingness in the coach self*)
T: tell him
C: please tell me what's going on, please let me help you, tell me what to do, I want to help you
T: SWITCH, what happens when you hear that? he's desperate, he wants to help you, he's so sad about the future you're heading for…
C: he's never asked me for anything, he just puts me down and pushes, for the first time I feel like I should be doing something, weird, I want to try (6 s) and I feel a bit sad but to be honest I don't know why I can't try, I just don't want to try
T: but do you want to understand how you end up not trying? because I think we can work on trying to understand that (*again 'piggy-back' on his need to understand)*
C: yeah, I've always wanted to know why I do this
T: SWITCH, so he says he wants to understand, are you on board with that?
C: yeah, for sure, anything

This was task agreement for the next level of split work, an anxious-avoidant split. This starts by instructing the

avoidant self to make the experiencing-self avoid. A part of D actually did want to leave his job and start his own firm and his anxious avoidant self 'went to town on that'. This split accesses the 'hide' coping strategy and the cost of that strategy. The core pain one hopes to access is the pain of being hidden and half-alive. The adaptive thrust one tries to support is the need and wish to truly live. Again note: 'exp-self' means 'experiencing-self'.

Vignette Level 2. The Avoidant Self-Split

T: put him in his cage, make him want to avoid
C: you're a dreamer, you can't start a new practice, you have no idea how much competition there is, no one will support you, no one will be your client, it's dog eat dog out there, you have debts to pay, you aren't even doing the job you have now, don't do it, you'll be worse off, upset Mom and Dad even more, they'll be mad, and judge you (*catastrophizing/secondary anxiety*)
T: so don't you dare, stay in your job, don't push it, play it safe
C: yes, he's where he should stay, I won't let him leave (*authority in this voice was palpable*)

The experiencing-self is now helped to be aware of how the anxious internal fear monger takes the rug out from under his need to try new things, to grow and to live. Importantly now the therapist gets the experiencing-self to experience what it's like to be caged. D did express in a heartfelt way what he longed for, and then the assertive grief and anger he needed to tell the anxious side that he wanted out, and would break out if needed. The therapist's maintains a genuine relationship with each side (often speaking directly to that side), with a matter of fact empathic connection to both.

C: …I'm so bored, I'm doing stuff a secretary should do, I'm not even working like a real lawyer
T: yes that's what's it like in that cage— what else? (*validate and bypass secondary frustration)*
C: I feel safe I guess (*the maladaptive relief that maintains the avoidance- by pass this as well*)
T: and? just close your eyes and focus on this, you will be there at that job for the rest of your days, what is it going to be like, to have him always telling you that it won't work and that you should play it safe, stay in your box (*focusing on emotional cost of avoidance)*
C: it feels like no wind in my sails, and that I can't do it, I feel weak, it's not worth living like this, I hate it, why do you think I'm surfing the web all day, it's the only place I get to live (*secondary blame emerges from shame*)
T: he makes you feel weak (*focus on primary maladaptive shame*) and then he says 'hide, you're weak'…what else though? what's it like alone in that cage, unable to try or 'show up'?
C: it's lonely, I can't achieve anything, he won't let me grow (*core pain of living dead)*
T: what do you want from him? (*holding him to the need that can support primary emotion*)
C: I want out, I want to live, I want him to let me try, I want to try *(thurst for life accessed)*
T: tell him I want to try (*once you arrive at the core need put that in contact with the other*)
C: I want to try
T: and what do you want from him—your jailor?
C: I don't know
T: just sit with it a bit…wouldn't it be nice if he believed in you? trusted you? wasn't so scared?
C: if he wasn't scared? Hmmm, yes, that's true I think, he's scared if I come out of this cage…
T: wow, yes I think you are onto something important, he's sort of like the 'wizard of oz' with smoke and a scary light show, but behind the curtain he's scared, trying to stop you from trying
C: yeah that's funny, weird, I never thought of him being scared, stopping me because he was scared of… (*adaptive cognition- new experience about a core other*)
T: yes, but right now, what do you need from him? stop protecting me? (*refocus him internally*)
C: yeah stop protecting me, you're smothering me, stop expecting me to play it safe and do nothing, I don't need protection, I can do this, I want to do this (*primary adaptive assertion*)
T: yeah, he smothers, yeah, so stop being so scared for me, stop thinking the only safe place for me is in this cage, I'm coming out to live my life, you aren't going to stop me, I can do it, believe in me, support me *(support adaptive anger & need for support*)
C: stop scaring me, I want to live, support me and trust me, I'm not an idiot
T: ok SWITCH, and what do you say now? will you let him out? can you support him?
C: sure I can let him out… (*a pause indicates something more is coming*)
T: but?
C: but he won't succeed at anything, he's going to fail
T: what makes you so sure? *(direct matter of fact communication with this part)*
C: because he's a loser, something is wrong with him *(marker of deeper criticism emerging*)
T: oh wow, so you really believe there's something wrong with him, that he's setting himself up for disaster? what is so bad about him? (*go for specific narrative to maintain arousal*)

C: he is mentally ill, he's gay, it's embarrassing, I hate it when he embarrasses us (*core pain)*
T: so you try to scare him so he won't shame and embarrass you, that's why you stop him (*pointing to the emotion regulating function of the catastrophizing)*
C: it's mortifying being embarrassed, it's awful (*core unregulated distress to avoid*)
T: yes for sure, no one likes that feeling, me neither, and you're sure he will embarrass you?
C: absolutely sure

What emerged in this split is the deeper critical and self-pathologizing core critic, the maladaptive 'coping by criticism' level of avoidant coping. Now the therapist moves to work on deeper core self-criticism. The avoidance-by-criticizing strategy must be fully activated and the painful consequences fully explored. The pain one accesses in the experiencing-self is the pain of being shamed and humiliated instead of supported and helped. The adaptive need for acceptance and support must also be accessed as well as supportive adaptive emotion, perhaps anger, to set boundaries on the critic's rejection/humiliation. The function of the criticism is also experienced.

Vignette Level 3: The Core Critic

T: ok so what is wrong with him?
C: he's gay for one, he'll never marry, hold down a job, you're always goofing off, you don't have any stamina, you're always depressed and anxious and getting mad, you're fat, and these pipe dreams you have about being some captain of industry, they're ridiculous ('*you' language indicates the critical self is active*)
T: so sounds like you're saying he's mentally ill and here are all the reasons
C: pretty much, cause he is (*he's doing to himself what has been done to him)*
T: how do you feel about him?
C: I think he's pathetic (*core secondary self–critical disgust and self-contempt activated*)
T: SWITCH, so what happens when you get that, how does he make you feel inside?
C: he's right (*he submits- un-individuated, caught in the maladaptive interpersonal cycle- this is a maladaptive response of a man, was once adaptive when as a child he faced a powerful other*)
T: and what does that make you want to do?
C: tell him to screw himself (*secondary anger—D counter attacks to escape pain)*
T: yeah, he's so sure something is wrong with you, so sure that you get caught in his spell and believe him and get stuck there, and remember that other sequence? you feel bad, and get mad (*regulating with some hot teaching- name the cycle and sequence*) (C: oh yeah, right) but is what he does helpful? does he motivate you to fix anything? (*back into experience)*
C: no
T: he doesn't help, he's like that sports commentator in the booth telling you you're no good, can't win, but he doesn't get on the field to help, he's safe up there in the booth looking down (*scaffolding adaptive anger and reflexivity*)
C: yeah it's true, he doesn't help me, he just judges me
T: sort of like your Dad did, how do you feel when he's doing that?
C: helpless, like crying again, like I felt in the kitchen (*core young maladaptive global distress*)
T: and what do you need from him? (*support his core need to access adaptive emotion*)
C: I guess to be on my side and to help me, stop judging me (*weak adaptive anger emerges*)
T: tell him (*direct him to put adaptive anger in contact with the other*)
C: help me, stop putting me down, get on the field and help me turn this game around, stop cutting my legs out from under me, nothing I do will be good enough anyway, he wants me not to be gay for god's sake, I can't change who I am (*adaptive self assertion*)
T: it's like he wants you to be someone else- D- my guess is that, like before, he is the one who is afraid over there, he's scared of you being other than who he believes you need to be (*pointing to how the critic regulates his core fear by being critical*) try this, "sorry I can't be someone else, this is who you have, me, gay fantasizing me, deal with it"
C: ok (*long pause)* what was it again? (*marker that the emotion has overwhelmed his cognition, can't remember what the therapist has just said*) oh yeah, I'm not perfect, deal with it
T: "accept me as I am"—I don't want to put words in your mouth, so just try them and let me know if they fit (*scaffolding his symbolizing in words but giving the client final authority*)
C: yeah accept me as I am (*need for attached support emerges)*
T: and does that feel right? (*checking with client*)
C: yes actually, it felt good to say that, not sure I could say it alone though (*acknowledges that therapist's support is still needed at this stage*)
T: yes, this is new, SWITCH, ok now you are the critic again, can you accept him as he is?
C: no

T: why not?
C: he's gay
T: oh, so that's the real problem for you over here, so if you stop criticizing him he'll do what? turn 'really gay?' start wearing leopard pants and dancing ? (*humourously exaggerate the fear*)
C: he might, and take drugs, and get AIDS, and crash and burn
T: you're really afraid of that
C: I'm not afraid, I'm angry, he's Catholic, he knows it's wrong *(secondary anger- judgement)*
T: but being gay doesn't mean he's going to change his whole personality, he's not even talking about gay stuff right now, he just wants you to stop making him feel like something is really wrong with him (*being the exp-self's champion here, a corrective experience*)
C: yeah, I know, it doesn't help, but he has to promise me he won't act gay before I can support him (*fear now emerges and demand that other help regulate that fear for him)*
T: that's what you want from him, let's see what he says, SWITCH, ok he's frightened that you're going to turn into a guy from gay town and get AIDS, and be promiscuous
C: he's nuts, I'm a reserved Catholic guy, I'm never going to be promiscuous or wear spandex
T: can you reassure him? (*request to meet the anxious critic's need for reassurance)*
C: sure, done. I'm not interested in a gay relationship, I just want to work better and be excited by working, leopard tights and drugs, are you kidding me? I'd never do those things, gay or not gay (*adaptive anger and some reassurance/soothing)*
T: so stop criticizing me and pathologizing me, but also 'get a grip' right? not only accept me as I am but actually get to know me as I am, you have no clue who I am
C: yeah I'm stunned actually, no wonder he was scared, I wouldn't be caught dead in a get-up like that, or ever do drugs- promise, no spandex, no drugs, I'm with him on that
T: ok, SWITCH, what happens here now?
C: I'm relieved a bit, and I do actually feel like I would like to get to know him a bit, maybe, that's a first (chuckle) but I'm still concerned…he's immature …
T: you don't trust him?
C: no, I don't trust him (*core self attitude of mistrust*)
T: tell him, "I don't trust you"
C: I don't trust you (*put it in contact with exp self*)
T: to do what?
C: to be competent, to succeed, to grow up, all that
T: how do you feel saying that? (*want to know if we have core fear or secondary anger*)
C: I'm kind of scared of him, he's nowhere near what Mom/Dad wanted. I actually feel a little sad right now too, but mostly fear, he's a loose cannon, I have to control him

Now the core frozen child emerges who fears losing the safety of connection. The important task now is to access the anguished and detailed narrative of that young self, its experience of aloneness and helplessness and its unmet needs for acceptance and support.

Vignette Level 4: Anxious Child/Soothing Split-Working with Trauma

Talking to the scared-child/critic side: T: ok I think we are getting to the core issue here D, the 'scared critic-you' here in this chair, you 'hire' D over there to keep you safe by following the rules, it's his job to be who he's supposed to be because you're the one who knows how frightening it is to be shamed and humiliated, don't you? and you decided long ago that you know the way to be safe—be who they want you to be, so what happened when you tried to be you, D? when you weren't who they wanted ?

C: well I tried and tried and I was good, and I did everything Dad said I should, I hid my brains, I didn't play sports because he told me I was no good at it, and I was always helpful (*we explore more of this early boyhood trauma narrative here. We explored that he was frequently made to feel 'wrong' and 'worthless' and that he began to avoid anything that would lead to being criticized and shamed by his father*)
T: so you learned to not spread your wings, to not trust yourself, to not cry, to feel alone and small and weak, and to hate feeling that, and then I guess you decided then to avoid anything that was unsafe, it's the only thing a young boy can do when no one helps him, you were alone and needed help (*validate current maladaptive fear as adaptive for the little boy*)
C: it was lonely
T: so alone, and I bet you were always anxiously trying to avoid anything that might lead to another bit of his contempt, or anxiously trying to be perfect so you wouldn't get it at all
C: yeah, pretty much
T: and what was it like trying so hard, hiding, stopping yourself
C: like I was worthless, something's wrong with me, scared of the next time, hiding, being quiet
T: I can fix this! just don't do anything bad, avoid or be perfect!
C: I did a pretty good job in high school but in university I started worrying others would find out, no girlfriend, I couldn't hide it anymore

T: so you felt so bad about yourself for so long, and scared, you needed big D to keep you safe by living up to your rules by avoiding, hiding and being perfect, to avoid being humiliated
C: mm-hm, but I'm angry at myself over there now, at big D, (*secondary anger about fear)*
T: because he's screwing up the plan, he's not doing his job, he's putting you at risk
C: mm-hmmmm, that's right, he's not keeping us safe
T: SWITCH, so what happens? do you hear what he's been through? he's so scared
C: yeah, I remember that, being 7 years old at the table, it was pretty awful
T: he got so afraid and felt helpless and overwhelmed, then he just wanted it all to go away
C: yeah I can see that. I see he's afraid
T: but?
C: but I can't be held hostage by him, it's nuts, I'm the hostage of a child
T: rude awakening right?, finding out that it's been your job to keep him from feeling fear and shame, it's been your job to manage his fears for him, so, what's it like to always keep him safe by not living and by being perfect, or avoiding any chance of growth and change, that's what you've been doing to keep him safe (*scaffolding pattern recognition and meaning*)
C: I'm angry, it's unfair, it's exhausting, it's not fair, I'm so tired of doing this job
T: so what do you want to do? (*access need*)
C: quit my job
T: you mean at work?
C: no, no, I mean quit my job taking care of him, I'm tired of doing what he needs to feel ok, I can't keep him that safe anyway, learning means trial and error and making mistakes
T: right, so tell him, I know you're scared but I have to learn, I can't keep you safe from failing, I will make mistakes and you need to be brave now and learn to tolerate that because failure will happen, I can handle it, I need you to be, it's time to be brave (*scaffold adaptive limit setting*)
C: yes I need you to be brave (*puts his needs first*)
T: SWITCH, and what happens over here in the scared boy part?
C: I want to be brave, but I'm not, I don't know how
T: do you need help to be brave?
C: I need him to take care of me,
T: you need him to be with you and to keep reassuring you that he's a grown man who can survive, that would help you be brave? (*accessing needs of scared child*)
C: yeah, yeah that would be good
T: SWITCH, so the little one needs support to be brave (2 s pause) D I think he needs you to soothe and reassure him and calm him a bit, so when he criticizes next time perhaps you can say "I see you're scared and I'll help you, you've done a good job trying to protect us but it's not working anymore, breathe, let go now, I'm going to protect us now"
C: wow, weird, yeah that would be good, I do feel like the stronger one here suddenly, I just never thought he needed me to help him
T: tell him you will help him and see what happens
C: I'll be there and I can help you, I'll learn how to help you and we'll do this together
T: SWITCH, and how does that feel over here for the scared boy-self?
C: I feel he's not ignoring me, I feel a bit better, some relief (*scared child soothed by support*)

As with D, the emotional core of the critical side of clients with AVPD's is often an overwhelmed scared self with core maladaptive fear. This child-self likely experienced the subjective 'trauma' of being emotionally overloaded before the capacity to regulate experience had fully developed. He then learned to fear and highly control his internal world (Pine 1986).

General Relationship and Experiential Scaffolding

The EFT therapist uses many relationship and experiential principles to guide the client with AVPD inwards towards feelings. First provide the client centered conditions of acceptance, genuineness, unconditional positive regard. The client with AVPD really needs explicit genuine appreciation for who they are. I often expressed to D that he was 'such a decent and smart man' and it deeply helped him that I admired something in him. Your trustworthiness will also be noticed as you even-handedly approach all their parts. The resulting interpersonal safety allows defensiveness to be calmed and a capacity to explore internal worlds to be accessed.

In addition, there is a need for *more* than empathic acceptance and a safe other. Use relentless warm gentleness to consistently direct clients with AVPD towards their internal experience.

Avoidant clients who retreat 'into the mind', make good use of a strong rationale to support the need to experience. Blatantly teach that feeling experiences are adaptive, unavoidable aspects of being human. Model unflappable survival and acceptance of emotion. When emotion is up and running teach about different types of emotion schemes, how to recognize them and what they are. For

example I taught D about Mowrer's (1947) avoidant paradox early in therapy.

T: when do you start web surfing? (C: right now when I'm mad) T: and feet better after (C:yeah) see, that's it right there- Mowrer would say you procrastinate to avoid feeling crappy, and end up procrastinating more because it works- we do more of whatever is followed by good feelings, you feel better after avoiding hated feelings so have trained yourself to procrastinate

This kind of hot teaching provides helpful emotion coaching that clients with AVPD have never had. Understand how 'allergic' the scared child is to feeling 'crummy feelings' and how much he/she insists on not engaging in any activity that will activate them. Straightforwardly challenge this. For example say things such as:

"If you are trying to never feel fear you're in big trouble. Fear is a part of life. In some situations, like in new strange situations, even lions feel fear. It's not because something is wrong with you, it's because you are alive. Fear is part of your emotional radar. We have to help you experience when your fear is adaptive or not—not avoid it—before we can do that, you are going to have to feel some fear. No way out of that one."

Finally a few words on therapist empathy. Empathy is more than expressed understanding. It can also mean responding to a client's present need, such as straightforwardly helping a client to regulate emotion when needed. Highly tolerant of aroused affect, able to endure its expression, knowledgeable of its problems and values, EFT therapists are particularly suited to emotion coaching clients with AVPD. They provide explicit psycho-education, help clients learn different opportunities for regulation within emotion scheme components. Clients become aware that arousal is not dangerous by definition. They also learn they will not be pushed to experience too much, and that emotion can be regulated *and* experienced. This lessens secondary fear that drives emotional avoidance.

Finally the client with AVPD will eventually be ready for UFB work with a negative other. D successfully differentiated from his father and held him accountable in an UFB intervention 2 years into treatment. "I'm not you. I'm gay and intellectual and it was your role to love and accept me for who I am instead of infect me with all your arrogant put-downs just because I was not you". Self-soothing interventions followed between a part that felt alone and unsupported and an 'adult supportive self'. Finally, a few months ago as coach/critic, he said to his experiencing self: "You knew all along that this law was boring us to death, and you wouldn't submit. You knew, we needed something new, you were the healthy one". He was experiencing new internal attachment. He was even taking chances in creative writing and a new potential computer systems business. He's working out, his posture and gait have shifted visibly and are more relaxed and fluid. In his latest session he said: "When I'm anxious now I don't avoid. I just ask myself- am I in any real danger here? I know I can do this, there is a part of me that is so confident, driving me forward, and yet I'm more gentle with myself too, and….uhm" "yes?" "I've been noticing cute guys". We both laughed together.

Conclusion

This paper has offered a developing EFT framework for working with the multiple layers of coping and avoidance present in clients with AVPD. Essential is understanding of the early interpersonal history in AVPD. Working systemically, even-handedly, empathically and warmly, provides accepting relational 'antidotes' to criticism and humiliation. Even-handed fairness to all the client's parts avoids alliance ruptures. Accepting, helpful, supportive 'hot teaching' from the EFT therapist scaffolds the client with AVPD to work effectively towards transforming the emotion schemes underlying the avoidance at the heart of this PD.

We therefore view EFT as a promising integrative treatment for AVPD. The dramatic nature of EFT chair interventions allow for emotional processing and transformation of emotion schemes at the heart of maladaptive interpersonal cycles to be accessed, experienced and reflected on. New awareness for us working in the EFT framework is that the inherent adaptive attachment at the core of the AVPD client is an internal attachment resource that the EFT therapist can bank on in when working with any side of a current split being worked with in chairs. Also important is the helpfulness of providing help in the form of good rationales and psychoeducation, which both feed the cognitive strength within the client with AVPD.

EFT for AVPD also satisfies the majority of conditions set forth by the APA Task Force on the treatment of personality disorders (Critchfield and Benjamin 2006). Clients with AVPD can change fundamentally. Core intra and interpersonal maladaptive interpersonal cycles active within the client with AVPD can yield when processed via experientially active chair work. An aware and informed EFT therapist trained in applying EFT for AVPD will find working with these clients satisfying and effective.

References

Ahmed, U., Gibbon, S., Jones, H., Huband, N., Ferriter, M., Völlm, B. A., et al. (2012). Psychological interventions for avoidant

personality disorder: protocol for a review. *The Cochrane Database of Systematic Reviews,*. doi:10.1002/14651858.CD009549.

Alden, L. E., Laposa, J. M., Taylor, C. T., & Ryder, A. G. (2002). Avoidant persoanlity disorder: Current status and future directions. *Journal of Personality Disorders, 16*(1), 1–29.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Benjamin, L. S. (2003). *Interpersonal diagnosis and treatment of personality disorders* (2nd ed.). New York: Guildford.

Beretta, V., de Roten, Y., Drapeau, M., Kramer, U., Favre, N., & Despland, J. (2005). Clinical significance and patients' perceived change in four sessions of brief psychodynamic intervention: Characteristics of early responders. *Psychology and Psychotherapy: Theory, Research and Practice, 78*(3), 347–362.

Borge, F., Hoffart, A., Sexton, H., Martinsen, E., Gude, T., Hedley, L. M., et al. (2009). Pre-treatment predictors and in-treatment factors associated with change in avoidant and dependent personality disorder traits among patients with social phobia. *Clinical Psychology & Psychotherapy, 17*, 87–99. doi:10.1002/cpp.640.

Borkovec, T. D. (2002). Life in the future versus life in the present. *Clinical Psychology: Science and Practice, 9*(1), 76–80.

Bowen, M. (1985). *Family therapy in clinical practice*. Lenham: Rowen & Littlefield.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock.

Carr, S. N., & Francis, A. J. (2010). Do early maladaptive schemas mediate the relationship between childhood experiences and avoidant personality disorder features? *Cognitive Therapy and Research, 34*, 343–358. doi:10.1009/s10608-009-9250-1.

Chambless, D. L., Fydrich, T., & Rodenbaugh, T. L. (2008). Generalized social phobia and avoidant personality disorder: meaningful distinction or useless duplication? *Depression and Anxiety, 25*(1), 8–19.

Critchfield, K. L., & Benjamin, L. S. (2006). Principles for psychosocial treatment of personality disorder: Summary of the APA division 12 task force/NASPR review. *Journal of Clinical Psychology, 62*(6), 661–674.

Damasio, A. (1999). *The feeling of what happens: Body and emotion in the making of consciousness*. Fort Worth: Harcourt College Publishers.

Dimaggio, G., Attinà, G., Popolo, R., & Salvatore, G. (2012a). Personality disorders with over-regulation of emotions and poor self-reflectivity: the case of a man with avoidant and not-otherwise specified PD, social phobia and dysthymia treated with Metacognitive Interpersonal Therapy. *Personality and Mental Health, 6*, 156–162. doi:10.1002/pmh.1193.

Dimaggio, G., Salvatore, G., Fiore, D., Carcione, A., Nicolo, G., & Semerari, A. (2012b). General principles for treating personality disorder with a prominent inhibitedness trait. *Journal of Personality Disorders, 26*(1), 63–83.

Dimaggio, G., & Stiles, W. B. (2007). Psychotherapy in light of multiplicity. *Journal of Clinical Psychology. Special Issue: Multiplicity of the Self in Psychotherapy, 63*(2), 119–127.

Eggum, N. D., Eisenberg, N., Spinrad, T. L., Valiente, C., Edwards, A., Kupfer, A. S., et al. (2009). Predictors of withdrawal: possible precursors of avoidant personality disorder. *Development and Psychopathology, 21*(3), 815–838. doi:10.1017/S0954579409000443.

Elliott, R. (2013). Person-centered/experiential psychotherapy for anxiety difficulties: Theory, practice and research. *Person-Centered and Experiential Psychotherapies, 12*(1), 16–32.

Elliott, R., Watson, J. E., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused Therapy*. Washington, DC: APA.

Emmelkamp, P. M., Benner, A., Kuipers, A., Feiertag, G. A., Koster, H. C., & van Apeldoorn, F. J. (2006). Comparison of brief dynamic and cognitive-behavioural therapies in avoidant personality disorder. *The British Journal of Psychiatry, 189*(1), 60–64.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Press.

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Journal of Psychotherapy Research, 17*, 15–30. doi:10.1080/10503300600720390.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused couples therapy: The dynamics of emotion, love and power*. Washington, DC: APA.

Greenberg, L. S., & Goldman, R. N. (2011). Case formulation in emotion-focused therapy. In T. D. Eells (Ed.), *Handbook of case formulation* (2nd ed., pp. 379–411). New York: Guildford.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-focused therapy for depression*. Washington, DC: American Psychological Association.

Hummelen, B., Wilberg, T., Pedersen, G., & Karterud, S. (2007). The relationship between avoidant personality disorder and social phobia. *Comprehensive Psychiatry, 48*, 348–356.

Kernerg, O., Yomens, F., Clarkin, J., & Levy, K. (2008). Transference based psychotherapy: An overview and update. *International Journal of Psychoanalysis, 89*, 601–620.

Livesley, W. J. (2003). *Practical management of personality disorder*. New York: Guildford.

Markus, H., & Nurius, P. (1986). Possible selves. *American Psychologist, 41*(9), 954–969.

Marques, L., Porter, E., Keshaviah, A., Pollack, M. H., Van Ameringen, M., Stein, M. B., et al. (2012). Avoidant personality disorder in individuals with generalized social anxiety disorder: what does it add? *Journal of Anxiety Disorders, 26*, 665–672.

Mowrer, O. H. (1947). On the dual nature of learning-a reinterpretation of "conditioning" and "problem solving.". *Harvard Educational Review, 17*, 102–148.

Muller, R. T. (2010). *Trauma and the avoidant client: attachment based strategies for healing*. New York: Norton.

Muran, J. C., Safran, J. D., Samstag, L., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy, 42*, 512–531.

Nicolò, G., Semerari, A., Lysaker, P. H., Dimaggio, G., Conti, L., D'Angerio, S., et al. (2011). Alexithymia in personality disorders. *Psychiatry Research, 190*, 37–42.

Paivio, S., & Pascual-Leone, A. (2010). *Emotion-focused therapy for complex trauma: An integrative approach*. Washington, DC: American Psychological Association.

Pine, F. (1986). On the development of the "borderline- child -to -be". *American Journal of Orthopsychiatry, 56*(3), 450–457.

Pos, A. E., & Greenberg, L. S. (2012). Organizing awareness and increasing emotion regulation: Revising chair work in emotion-focused therapy for borderline personality disorder. *Journal of Personality Disorders, 26*, 84–107. doi:10.1521/pedi.2012.26.1.84.

Pos, A. E., Greenberg, L. S., & Warwar, S. (2009). Testing a model of change in experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 77*, 1055–1066. doi:10.1037/a0017059.

Reichborn-Kjennerud, T., Czajkowski, N., Torgensen, S., Orstavik, R. E., Tambs, K., & Kendler, K. S. (2007). The relationship between avoidant personality disorder and social phobia: A population based study. *The American Journal of Psychiatry, 164*(11), 1722–1728.

Rettew, D. C., Zanarini, M. C., Yen, S., Grilo, C. M., Skodol, A. E., Shea, M. T., et al. (2003). Childhood antecedents of avoidant personality disorder: A retrospective study. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(9), 1122–1130. doi:10.1097/.01.CHI.0000070250.24125.5F.

Spinhoven, P., Bamelis, L., Molendijk, M., Haringsma, R., & Arntz, A. (2009). Reduced specificity of autobiographical memory in Cluster C personality disorders and the role of depression, worry and experiential avoidance. *Journal of Abnormal Psychology, 118*(3), 520–530.

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., et al. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74*(2), 337–345. doi:10.1037/0022-006X.74.2.337.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry, 58*, 590–596.

van Velzen, C. J., Emmelkamp, P. M., & Scholing, A. (2000). Generalized social phobia versus avoidant personality disorder: Differences in psychopathology, personality traits, and social and occupational functioning. *Journal of Anxiety Disorders, 14*, 305–411.

Wolfe, B., & Sigle, P. (1998). Experiential psychotherapy for the anxiety disorders. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 272–294). New York: Guildford.